Corporation for National and Community Service

2010 Social Innovation Fund

Foundation for a Healthy Kentucky

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2010 Social Innovation Fund

Foundation for a Healthy Kentucky

Section 1 – Application

PART I - FACE SHEET

APPLICATION FOR FEDERAL ASSISTANCE

Modified Standard Form 424 (Rev.02/07 to confirm to the Corporation's eGrants System)

1. TYPE OF SUBMISSION:
Application [X] Non-Construction

2a. DATE SUBMITTED TO CORPORATION FOR NATIONAL AND COMMUNITY SERVICE (CNCS):	3. DATE RECEIVED BY STATE:	STATE APPLICATION IDENTIFIER:
04/07/10		
2b. APPLICATION ID: 10SI116273	4. DATE RECEIVED BY FEDERAL AGENCY: 04/07/10	FEDERAL IDENTIFIER: 10SIHKY001

5. APPLICATION INFORMATION

LEGAL NAME: Foundation for a Healthy Kentucky

DUNS NUMBER: 067806120

ADDRESS (give street address, city, state, zip code and county):
9300 Shelbyville Road
Suite 1305
Louisville KY 40222
County: Jefferson

NAME AND CONTACT INFORMATION FOR PROJECT DIRECTOR OR OTHER PERSON TO BE CONTACTED ON MATTERS INVOLVING THIS APPLICATION (give area codes):

NAME: Susan Zepeda

TELEPHONE NUMBER: (502) 326-2583

FAX NUMBER: (502) 326-5748

INTERNET E-MAIL ADDRESS: szepeda@healthy-ky.org

6. EMPLOYER IDENTIFICATION NUMBER (EIN):
311784753

7. TYPE OF APPLICANT:
7a. Non-Profit
7b.

8. TYPE OF APPLICATION (Check appropriate box).

[X] NEW [ ] NEW/PREVIOUS GRANTEE

[ ] CONTINUATION [ ] AMENDMENT

If Amendment, enter appropriate letter(s) in box(es): [ ] [ ]

A. AUGMENTATION B. BUDGET REVISION

C. NO COST EXTENSION D. OTHER *(specify below):*

9. NAME OF FEDERAL AGENCY:
Corporation for National and Community Service

10a. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER:94.019

10b. TITLE: Social Innovation Fund

11.a. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:
Kentucky Healthy Futures Initiative

11.b. CNCS PROGRAM INITIATIVE (IF ANY):
SIF - Geographic Healthy Futures

12. AREAS AFFECTED BY PROJECT (List Cities, Counties, States, etc):
Kentucky

13. PROPOSED PROJECT: START DATE: 08/01/10 END DATE: 07/31/11

14. CONGRESSIONAL DISTRICT OF: a.Applicant b.Program

15. ESTIMATED FUNDING: Year #: 1

a. FEDERAL	$ 2,023,200.00
b. APPLICANT	$ 2,023,200.00
c. STATE	$ 0.00
d. LOCAL	$ 0.00
e. OTHER	$ 0.00
f. PROGRAM INCOME	$ 0.00
g. TOTAL	$ 4,046,400.00

16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?

[ ] YES. THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON:

DATE:

[X] NO. PROGRAM IS NOT COVERED BY E.O. 12372

17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?

[ ] YES if "Yes," attach an explanation. [X] NO

18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT, THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.

a. TYPED NAME OF AUTHORIZED REPRESENTATIVE:	b. TITLE:	c. TELEPHONE NUMBER:
Susan Zepeda	Executive Director	(502) 326-2583

d. SIGNATURE OF AUTHORIZED REPRESENTATIVE:	e. DATE SIGNED:
	04/07/10

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Executive Summary

Title: Kentucky Healthy Futures Initiative

Intermediary: Foundation for a Healthy Kentucky (Foundation)

Geographically-Based Healthy Futures SIF: To support underserved rural and low-income areas of Kentucky

Grant Amount Requested: $1 million per year for up to 5 years (plus indirect costs)

Pre-selected Subgrantees: Yes (Barren River District Health Department; $250,000)

Program Design:

The Kentucky Healthy Futures Initiative (KHFI) will support nonprofit organizations to develop and pilot innovative, replicable strategies to improve the health of Kentucky's rural and lower income communities. KHFI builds on the Foundation's Local Data for Local Action (LDLA) Initiative, and offers a mix of grants, training and technical assistance (TA) to community groups with a "big idea" for improving the health of their community.

Qualifications and Track Record: The Foundation's mission is to address the unmet health needs of Kentuckians. We seek to promote lasting change in the systems by which health service is provided and healthy lifestyles maintained, improve access to needed services, reduce health risks and disparities, and promote health equity.

Since 2002, the Foundation has funded over $10 million in planning grants and demonstration projects.

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We provide for rigorous external evaluation of grants, offer technical assistance (TA) and training to grantees, and use learnings from demonstration projects to promote replication of effective approaches and policy change to foster sustainability. Many Foundation-funded projects have successfully sustained community innovations that support better health and health care access.

Subgrantees will be identified through a rigorous, competitive open Request for Proposals (RFP) process. Using the Foundation's established process, staff will conduct a preliminary review of each proposal for completeness. Then, members of the Foundation Grants Committee review the proposals, augmented by external reviewers with topical expertise. Site visits are conducted prior to the Committee's deliberations, and recommendations go to the full Board for final approval and funding. We are prepared to add further review elements as may be required by the Corporation for National and Community Service (the Corporation).

Subgrantee Support and Evaluation: Building on the Foundation's experience with similar initiatives, subgrantees will be supported through a quarterly workshop series to (1) increase awareness of community data and resources, (2) build skills for strategic planning and coalition-building, (3) support development of a business plan and financial pro forma, and (4) implement rigorous internal evaluation. Experts conducting the workshops will be available to participants for follow-up TA. All grantees will be evaluated by an external team from the Center for Community and Health Evaluation (CCHE).

Organizational Capacity:

The Foundation has net assets of over $52 million and an annual grants budget of $2 million to $2.5 million.

The Foundation has a staff of six: an Executive Director, Program Manager, Program and

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Administrative Coordinator, and three Program Officers. Arrangements with a CPA firm, investment advisor and other external vendors permit us to remain flexible and accountable, while minimizing our administrative footprint. Ongoing vendor relationships are evaluated annually and rebid every five years.

We have rigorous procedures for review, monitoring and management of Foundation grants. All grants are entered in GIFTS software and tracked by staff to assure timely issuance of checks, receipt of required deliverables, and scheduling of site visits. The Foundation identifies and contracts for TA targeted to the needs of grantees.

Cost-Effectiveness and Budget Adequacy:

Of the $1 million requested, the Foundation proposes to subgrant $820,000 (82%).

We will provide at least 1:1 match for the full $1 million and provide a like match for the associated indirect costs.

All funds proposed for match are Foundation assets.

The $2 million/year to be dedicated to KHFI will include $200,000 for external evaluation; $80,000 for an additional dedicated Program Officer supporting this Initiative; and $80,000 in support of training, TA, travel and communications.

Program Design

A. GOALS AND OBJECTIVES

The Kentucky Healthy Futures Initiative (KHFI) will produce measurable improvement in the health of project participants in 6 to 10 low-income and rural communities by July 2013. KHFI will serve some of

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the most historically underserved parts of Kentucky, including counties in Appalachia. KHFI will demonstrate the effectiveness and replicability of innovative strategies for preventing illness and accessing needed health services. In short, KHFI aims to help communities do "one smart thing" to measurably improve the health of their residents.

KHFI will provide a proven, structured program for promoting community-specific social innovation to reduce health risks in rural and low-income areas of Kentucky. With SIF funding, the Foundation for a Healthy Kentucky (Foundation) will offer subgrantees a blend of funding, training and technical assistance (TA). This approach is already making a significant difference in the health of several Kentucky communities through two initiatives currently funded by the Foundation: Local Data for Local Action (LDLA) and Shaping Kentucky's Future (SKF). KHFI, a new and multidimensional program, will use SIF funding to achieve greater gains for more of the state's neediest areas.

The Foundation is a public charity with an endowment currently valued at over $52 million; it makes between $2 million and $2.5 million in grants each year. Of this, the Foundation's 2010 budget provides over $1 million in funding for grants under the LDLA Initiative, and additional resources for training and evaluation (conducted independently by the Center for Community and Health Evaluation (CCHE)). The Foundation also budgets $100,000 for SKF, matched by the state's community foundations. LDLA funds will provide the needed match for KHFI in the initial project year; additional KHFI funds will be allocated in 2011.

In addition to grantmaking, the Foundation sponsors targeted research, forums, training programs, and TA. As a local health data resource for all Kentucky, the Foundation funds a website, www.kyhealthfacts.org, populated with data analyzed by the Kentucky State Cabinet for Health and Family Services (CHFS) and epidemiologists at the University of Kentucky (UK).

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KHFI subgrantees that can demonstrate the required match will receive an initial grant providing for a planning period - with training and TA to develop a business plan and financial pro forma to create an innovative, sustainable strategy to improve the health of their community - and begin putting that plan into action. Second and third year support will be contingent on ability to implement the planned demonstration project. First year support is a grant; in subsequent years, support may consist of a mix of outright grants (of $100,000 or more) and loan guarantees in support of capital construction. In the latter, the Foundation is prepared to stand in second position on loans for capital construction and equipment, secured from a local lending institution. One current grantee and its funding has been included in the proposed KHFI match. A request for proposals for new grant sites will be issued later this calendar year. A four-part training series is underway, to support this work, and will be repeated in 2011 with SIF funding.

Target Community: Priority will be given to rural and low-income areas of Kentucky.

Priority Areas: KHFI will invite applications testing innovative strategies to increase physical activity, improve nutrition, reduce smoking rates and/or increase access to needed health services (including dental and behavioral health) in underserved communities.

Kentucky faces profound challenges for almost all aspects of health. The United Health Foundation ranks Kentucky 41st overall, making it one of the least healthy states in the nation (1). The overall mortality rate for Kentucky is 897.6 deaths per 100,000 population, this is well in excess of the national rate of 760.3 (2).

Chronic disease presents a major problem for the Commonwealth. For example, Kentucky has the

highest burden of cancer mortality in the nation, due in large part to the high rate of lung cancer in the state (3). The rate of death due to lung cancer is 124.8 per 100,000 in Kentucky, more than 50% higher than the national rate (82.7 deaths per 100,000). The excess lung cancer burden is related to the high rates of tobacco use in Kentucky. While the prevalence of smoking has declined in recent years, Kentucky rates continue to exceed the national average (4). Fayette County, the first county in the state to pass a smoking ban, boasts the lowest rate of tobacco use in the state with only 19% prevalence of smoking. Unfortunately, other Kentucky counties have smoking rates as high as 36% (5).

In addition to smoking, other lifestyle factors contribute to poor overall health status in Kentucky. In 2008, 29.8% of Kentucky adults were obese (6). The prevalence of obesity is higher in more rural parts of the state, particularly in Appalachia. County-level obesity rates range from 23% to 37% (7).

Substance abuse is another area of concern: approximately 8.4% of the Kentucky population aged 12 and older reported using an illicit drug during the past month, well above the national average of 8% (8). Prescription drug abuse is an issue of particular concern in Kentucky. More than 6% of Kentuckians aged 12 and older reported nonmedical use of pain relievers in the past year (26% higher than the national average) (9).

Social factors play an important role in the health of Kentuckians. Educational attainment is comparatively low in the state. At the time of the 2000 Census, just 72% of Kentuckians age 25 and older had completed high school or received their GED. Residents of eastern Kentucky are less likely to have completed high school, and in two counties, Owsley and Clay, fewer than half of all adults complete high school (10).

KHFI was developed as a Geographic Healthy Future project to focus on neediest areas of the state. In

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2010, 40 Kentucky counties were classified as distressed by the Appalachian Regional Commission. In Louisville, Kentucky's largest city, limited access to grocery stores and fresh produce has been documented in several low-income neighborhoods. These so-called "food deserts" present a barrier to healthy eating for large segments of the community (11).

Because Kentuckians face many community-specific health challenges, KHFI will draw on local wisdom to identify priority health issues and innovative responses. By combining access to sound local health data (through www.kyhealthfacts.org and other resources) with targeted skill-building training, the Foundation will help communities to identify solution strategies that enjoy strong support from local stakeholders.

Measurable Outcomes Proposed: Once subgrantees are selected, the Foundation will use a collaborative approach involving local stakeholders and evaluation specialists to select indicators of progress in health improvement projects. It is anticipated that these indicators will include standard, quantitative measures (e.g., BMI, preventable hospital admissions, number of smoke-free businesses), as well as newly-formulated indicators adapted to the goals of individual grantees. Cross-cutting indicators will capture diverse accomplishments in a manner that can be aggregated across sites. These will include indicators of systems change resulting from projects, capacity building, coalition functioning, connections with other community agencies, leadership development, and leveraging funds/securing matching funds. Data will be collected from subgrantees by methods such as interviews and reports to the Foundation; secondary data will also be used, as appropriate.

Availability of Relevant Data: Data relevant to cross-cutting indicators will be provided primarily by subgrantees. To isolate the impact of the funded intervention on observed outcomes, projects will be assisted in identifying control groups-either comparable populations not participating in the identified

program, or cohorts whose participation is time-delayed to permit service as a control group prior to engagement. Secondary data, such as the American Community Survey, vital statistics, and the Behavioral Risk Factor Surveillance System (BRFSS) (for which the Foundation funds periodic oversampling of key population groups and county-level analysis of data), will also offer potential cross-cutting indicators.

Organizational Qualifications: The Foundation is committed to improving health in Kentucky and to evaluating the impact of its work. Foundation staff have expertise in the areas of public health, social psychology, business, and health administration. The Foundation uses a well-documented and transparent process for solicitation, selection, monitoring and evaluation of programs and individual grantees. Our partnerships with the University of Louisville (UofL), UK and state government agencies extend the breadth of our staff capacities. Our external evaluations are provided by a well-regarded national firm, CCHE, and overseen by an advisory board of national and local experts on health and evaluation issues.

B. USE OF EVIDENCE

The Foundation has a track record of using rigorous evidence and evaluation tools to select and invest in grantees, to support and monitor the replication and expansion of subgrantees, and to achieve measurable outcomes.

We recognize the challenges involved in engaging community-based nonprofits in underserved rural areas in rigorous impact assessment to attain strong measures of program effectiveness. Working with local and national evaluation research experts, the Foundation is prepared to build a portfolio of SIF subgrantees that, taken together, will allow us to provide clear evidence of strong programmatic impact.

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The Foundation is currently midway through its first set of five-year initiatives, each of which has a strong external evaluation plan. CCHE is evaluating four of these initiatives and will evaluate KHFI as well. Each of the initiatives has a clear logic model, developed with input from funded grantees; progress is tracked through a combination of direct measures, surveys and key informant interviews. Information from these annual assessments is used to make project modifications to enhance their effectiveness. To date, we have preliminary and promising evidence that programs and projects funded by the Foundation have contributed to: more than 25% of Kentuckians now living in communities where smoking is prohibited in buildings open to the public; concerted community action resulting in a doubling of the Kentucky tobacco tax in 2009; promising outreach models to reduce rates of dental caries in youth; increased access to affordable, safe and effective care through federally-qualified health clinics and innovative school-based health programs.

In addition, CCHE works directly with grantees, to build evaluation capacity and foster use of evaluation as a management decision-making tool. One of the goals of evaluation planning and training will be to increase the number of programs that have moderate to strong evidence of program effectiveness.

CCHE is nationally recognized for its evaluation work, with clients including the Centers for Disease Control and Prevention, American Cancer Society, Robert Wood Johnson Foundation, W.K. Kellogg Foundation, and Kaiser Permanente. Study methodologies pioneered and used by CCHE include participatory evaluation and logic model case studies. Participatory evaluation is particularly well-suited to assessment of community-based programs, since conceptualization of indicators and procurement of data depends heavily on program staff and community residents. Logic model case studies integrate a variety of qualitative and quantitative data, and postulate sequential linkages among inputs, intermediate results, and final outcomes. This methodology is effective for evaluation of complex multi-

faceted interventions in community-based programs; it can provide a means of inferring causal linkages between inputs and outcomes.

The Foundation uses evaluation data to improve the quality of its programs and promote successes of its grantees. The Foundation's Board of Directors has committed 10% of initiative-related expenditures to prospective evaluation so that issues and areas of improvement can be identified and addressed in a timely manner; the same will be the case for KHFI. Data collected includes input from Foundation staff, its grantees, other contractors/consultants involved in the initiatives and external stakeholders to ensure all perspectives are represented in the evaluation findings. The Foundation receives formative feedback from external evaluators monthly and it is used by the Foundation Board and Community Advisory Committee (CAC), in addition to annual evaluation reports, to inform strategic planning and guide initiative adjustments. Some examples of adjustments made as a result of evaluation findings include:

1) Requiring future LDLA grantees to focus their work on one county or one coalition, because LDLA sites with larger jurisdictions experienced more challenges than those working with a smaller area;

2) Funding TA in additional (non-grantee) counties with high need, because TA provided through the Primary Care initiative had more impact than Foundation funding; and

3) Investing in improved communication strategies because many state-level key informants were not aware of the Foundation's role in the initiatives.

In selecting grantees to fund, among competing applicants responding to Foundation RFPs, the Foundation seeks those able to present compelling evidence of the need for a proposed intervention and show how it differs from approaches already in place or replicates a model successful elsewhere. Foundation grantees usually receive only a portion (generally half or one-quarter) of the requested funds upon completion of a fully-executed Agreement, describing the nature of the project funded and

outlining milestones of accomplishment. Subsequent investment of funds requires submittal of a narrative and financial report showing progress consistent with the proposed timeline for implementation. A mid-project site-visit provides added information on grantee progress.

The primary goal of this internal review of grantee performance is to assess grantee progress in implementing their proposed approach, and to observe impacts of interventions on project participants. Impact measures vary with the purpose of the project, and may include readily quantifiable measures (e.g. clinic utilization) and self-reported data and perceptions.

The goals of the external CCHE evaluations are to assess effectiveness of initiatives (including grants, training, TA) and to identify areas for future improvement. As discussed above, findings of these evaluations have resulted in adjustments to specific initiatives and to the Foundation's strategic plan. While these initiatives are still in implementation, the Foundation and CCHE have plans to disseminate evaluation data to state and national audiences and use evaluation data to advocate for needed policy change related to each initiative. Copies of annual Initiative evaluation reports are available at http://www.cche.org/cche_publications.html

The evaluation design for initiatives includes a set of cross-cutting questions:

1) Has the initiative been effective in advancing the Foundation's health policy objectives?

2) What aspects of the initiative's design/implementation have contributed to the impact?

3) What has been the impact of program participation on the grant recipients?

4) What can be done in future initiatives to increase the likelihood of advancing the Foundation's health policy objectives?

For each initiative, the evaluation design includes an initiative logic model, sub-evaluation questions

(that fall under the cross-cutting questions), and quantitative and qualitative indicators. The design, agreed upon by Foundation staff, a national advisory committee for the evaluation, and CCHE in Year 01, has been revisited yearly to reflect input from initiative grantees and program changes.

CCHE evaluations include interviews and site visits with grantees, web-based surveys of participants, community key informant interviews, document review of relevant reports submitted to and produced by the Foundation, and secondary data analysis. Site visits and interviews are conducted with the aid of observation guides to yield data systematically collected by uniform means. Qualitative data are analyzed using Grounded Theory analytical methods to identify intrinsic themes derived from the data and to code and categorize the data (12). The themes thus identified are grouped into categories outlined in the logic model and reviewed using the constant comparison technique to determine whether or not themes belong in a particular category. This process is aided by the use of the Atlas.ti software package. Quantitative data from the web-based surveys are compiled by SurveyMonkey. When appropriate, descriptive statistics and chi-squared analyses are conducted using SPSS 10.1.

Formal reports of evaluation findings are prepared annually by CCHE. A full evaluation report is provided to the Foundation staff and governing bodies. Initiative-level briefs are compiled to share with grantees and other stakeholders. Formative feedback is provided during monthly conference calls between the Foundation and CCHE. Although the Foundation's LDLA program is relatively new, CCHE has extensive experience in the operative methodology and has publications (13-15) extensively describing it.

Sharing and Integrating Lessons

As stated earlier, the Foundation has consistently invested in initiative-level evaluation. These evaluations gather data from all grantee sites and look for common themes including accomplishments,

success factors, challenges, and lessons learned. Evaluation data are shared with the Foundation's staff and governing bodies in a yearly formal report, and more informally-with staff, grantees, and the Foundation's Board and CAC -as themes are identified throughout the year. Evaluation data are used to identify areas of success and areas for improvement. Annual evaluation findings are also shared with all grantees and other stakeholders who participated in the evaluation activities (key informants, TA providers). The Foundation provides opportunities for grantees to discuss their own evaluation efforts and encourages sharing across sites to promote mutual learning (discussed below).

Assessment of Subgrantee Evidence

Barren River Health District has presented a logic model for their intervention-a mobile dental clinic-as well as a business plan and financial pro forma demonstrating financial viability. The model itself has preliminary evidence of program effectiveness, based on similar programs implemented elsewhere. The project is in its second month of implementation.

C. COMMUNITY RESOURCES

The Foundation is the proposed Intermediary in this application. Although we work collaboratively with CHFS, and with community foundations throughout the Commonwealth, we are the only entity providing the required match to obtain these funds. We anticipate assisting qualified subgrantees to pursue their own required matching funds from these and other entities.

D. DESCRIPTION OF ACTIVITIES

1. Subgranting

In working with community organizations that may have an innovative idea but may lack experience in business/strategic planning, research design and evaluation, we find that a combination of a planning period in the initial grant year, training and TA increase the likelihood of obtaining a rigorously planned

and designed proposal for implementation/demonstration funding. To select grantees to receive planning funds, the Foundation will require:

1) A strong theory of change, whether articulated as a logic model or simply set forth as a compelling argument for a process by which to identify promising interventions to address identified community health risks.

2) Strong leadership and financial and management systems, including data management, in the grant recipient, who may serve as fiscal agent for a cross-sectoral planning group designing the proposed intervention.

3) Strong community relationships, which, we believe, are critical to obtaining needed community investment for the long term in strategies to be identified for reducing health risks in the targeted areas. Some relationships will manifest in provision of required financial match and others in important local knowledge. This is particularly important going forward, as the Foundation is committed to working on social innovation through a health equity lens.

4) At the end of the planning period, during which training and TA are provided, applicants will be expected to develop a business/strategic plan and financial pro forma for implementation of the proposed social innovation. This is to ensure that projects are begun with sustainability in mind.

By the end of the planning period within the first funding year, the applicant will need to further demonstrate:

5) A strong financial position, reflecting funding diversity, sufficient resources to provide dollar-for-dollar match throughout the implementation/demonstration period, and the ability to sustain the innovation with funds from other sources once the demonstration period is complete.

6) Ability and commitment to use data and evaluation for performance and program improvement; skills in this area will be enhanced during the planning period with targeted training and TA.

7) Likely effectiveness of the proposed innovative approach as demonstrated by places where similar

innovations have been successfully introduced, or the applicant's success in attaining measurable success in similar endeavors.

8) Potential for replication or expansion of the proposed innovative approach in other rural, low-income and/or underserved communities.

9) A well-defined plan showing how they will attain the proposed measurable outcomes in areas important to the health of Kentucky, how they will evaluate program effectiveness and use this information for continuous program improvement, and how they will replicate or expand successful strategies in future years.

10) A specific commitment to use funds obtained from SIF and the Foundation to support, replicate and/or expand the identified promising innovative program.

The Foundation has a clear track record with this approach. In LDLA, the Foundation has made first year grants to seven organizations, and second year grants to five. Grantees have included local health departments, a state university, a county board of education, and an independent community-based organization. Each of these grantee organizations provides support and direction to one or more community coalitions. In this way, the Foundation provides grants, data and TA and assures a breadth of community input, while ensuring the structure, accountability, expertise, and ability to act on decisions that an established organization possesses.

Criteria specified by the Corporation are consistent with those currently applied by the Foundation, and these will be extended in the following manner:

1) Strong theory of change: Current LDLA grantees have been required to demonstrate their thinking and focus through a concrete action plan. This action plan, in turn, must be based on a theory of change. Action plans and their basis in theories of change will be key review criteria for future KHFI subgrantees. Because potential subgrantees may not have experience with this process, the Foundation

endorses funding a planning period in a first grant. As was observed with grantees under the LDLA initiative, it is anticipated that planning funds and associated TA will promote effective action planning in this new group of subgrantees.

2) Leadership, financial and management systems: In evaluating applicant organizations for the KHFI, the Foundation will apply a set of "readiness criteria" including evidence of leadership, staffing, and organization of sufficient strength and experience to achieve the proposed objectives.

3) Financial strength and diversity: The current portfolio of LDLA grantees illustrates the Foundation's practice of awarding grants to organizations and agencies clearly capable of sustainability. Most current grantees are well-led and established community organizations. Under a potential Corporation grant, the Foundation will require dollar-for-dollar match from subgrantees, and may assist them in diversifying their funding base as needed, through applications to community and corporate foundations.

4) Strong community relationships: Possession of strong community ties has been a key criterion for grant awards under LDLA and will be under KHFI. Strong community relationships are essential for both planning and implementation. Initially, grantees are required to provide a list, with contact information, of organizations and their leadership who are committed to assisting in the proposed effort.

5) Track record of using data and evaluation for program improvement: The Foundation makes health data available to local nonprofit organizations, providing them with TA in data analysis and application, and promoting development of innovative local data-based health interventions. A key resource is the Foundation's Kentucky Health Facts website. Through access to data (broken down to small geographical units) and TA, the Foundation has enabled a large number of grantees to use rigorous evidence for place-based planning and decision-making. LDLA has promoted large-scale and more sophisticated use of data as well as requiring primary data collection to get community input on health priorities. With a SIF grant, KHFI will continue this emphasis. In LDLA, and we expect in KHFI, some

promising applicants lack significant experience in use of health-related data. In these instances, the Foundation provides training, TA, and links to grantees with strong data track records to share best practices. In this way, subgrantees with high potential for significant future work with data can become eligible to receive funding, adding evaluative rigor to community innovation. In addition to the CCHE initiative-wide evaluation, all subgrantees under KHFI will be provided with resources and required to conduct self-evaluation.

Effectiveness and measurable outcomes: Decisions regarding LDLA grantmaking emphasize the potential for grantees to achieve measurable outcomes, either as evidenced by track record or by willingness of newer and less experienced organizations to acquire skills needed to produce measurable outcomes. The Foundation anticipates a similar mixed approach (assessing track record and teachability) in making KHFI subgrants.

The Foundation has placed strong emphasis on promoting replication of achievements and best practices of current grantees, as well as fostering local use of practices tested elsewhere. This is encouraged by regular grantee convenings and webinars, with a commitment to participate as an explicit grant requirement. The intermediary will continue its current two-level approach to outcome measurement: 1) Each grantee is required (as indicated above) to have a clear action plan, either initially proposed or to be developed in an initial planning period of the grant; and 2) the Foundation itself has an action plan for KHFI with outcomes aligned with the strategic plan for the Foundation as a whole. The action plan for KHFI entails both measurement at the subgrantee level and tracking achievements under the logic model for the Initiative itself.

The Foundation casts a wide net to identify subgrantees with impact potential (i.e. ready to combine measurement rigor with knowledge of local conditions in rural, low-income and underserved areas of

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the Commonwealth). In addition to publicizing funding opportunities through our extensive contact list, we reach out through partnerships with the Leadership Kentucky, Kentucky Rural Health Association, Kentucky Primary Care Association, Kentucky Hospital Association and Kentucky Public Health Association. As in LDLA, the Foundation will select KHFI subgrantees with a:

1) Clear understanding of the communities they serve;

2) Clear understanding of the needs for health care access and health improvement in the communities served;

3) Strong ties to the local community and to public agencies and private (non-profit and for-profit) organizations as required to achieve their objectives;

4) Ability to lead a local coalition capable of making the changes sought;

5) Articulation of a clear theory of action (specified in a logic model) accompanied by an action plan with concrete steps for achieving objectives and indicators for measuring the degree to which objectives have been achieved;

6) Readiness to achieve the objectives specified as indicated by strength of leadership, adequacy of staff and financial accountability systems, and track record in achieving results in earlier work (or demonstrated high potential for such achievement); and

7) Willingness to attend and contribute to convenings and to make effective use of TA resources provided by the Foundation and CCHE.

For applicants not ready to move to implementation at the outset, as a KHFI subgrantee, the Foundation will provide TA during an initial planning period to conduct a community assessment, identify an innovative approach to a critical local health issue, and design a rigorous plan to carry it out. Data on the ability of grantees to achieve their objectives are intensely scrutinized during initial grant periods and are used by Foundation decision-makers to determine which grantees to fund for further work.

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Examples of competitiveness, effectiveness of approach: Examples of Foundation success have been noted above. Two others, where the Foundation provided pilot funds to support health innovation, include an effort to demonstrate the effectiveness of putting seniors in charge of their own home care service decision-making, reducing the need for institutionalization in long-term care facilities that was subsequently "taken to scale" by the state, and a demonstration project to support e-prescribing in offices of rural providers and those serving low-income patients who might otherwise not have been able to migrate their practices to electronic systems, also expanded by the state subsequent to the pilot we funded. Perhaps equally important, are the recipients of modest planning grants who, at the end of a year or longer, were unable to develop a rigorous plan for implementation and avoided a larger, failed investment.

The Foundation maintains relationships with a broad network of experts, leaders, and community stakeholders, and operates under two governing bodies-a fifteen member Board of Directors and a 31-member CAC. Both entities require participation from stakeholders across the state. The Foundation also has a wide network of consultants and partners that contribute to its work; these entities include both state level organizations (such as Kentucky Primary Care Association, CHFS, UK) and national organizations (such as Prevention Institute, Health Management Associates, National Academy for State Health Policy, Community Catalyst, and CCHE).

Additionally, the Foundation and CCHE have convened a national advisory committee to ensure the quality of the evaluation activities. This committee meets every six months and discusses the evaluation plans, findings, implications for the initiatives and potential areas for further dissemination.

1) Under the Corporation grant, the Foundation will engage its state partners in the dissemination of the RFP for subgrantees and in the identification of potential subgrantees. The Foundation will continue to

engage its state and national partners in the provision of relevant TA, and the evaluation national advisory committee to guide evaluation efforts. The one pre-selected subgrantee has completed a planning process under the Foundation's LDLA Initiative, and obtained support to begin a demonstration phase.

2) The Foundation is committed to providing TA to subgrantees to achieve their measurable outcomes, including replication and expansion. The basic tools we use to accomplish this are the provision of group training (workshops and webinars), individualized (site-specific) TA, funding and promoting availability of data for local decision-making, and, where needed, loan guarantees to assist subgrantees in obtaining access to needed investment capital.

3) The Foundation has a history of building positive working relationships with subgrantees and effectively communicating that we want them to succeed. The multi-year funding process we use, in which each next year of funding is contingent on successful performance in the prior year, helps to assure sustained effort and engagement throughout the funding period, building long-term relationships while addressing short- and long-term goals. Each Agreement includes a timetable and milestones for achievement. Workshops with subgrantees are augmented with site visits and teleconferences. Modifications, where needed, are discussed with the subgrantees and documented so that there is no misunderstanding regarding a changed outcome measure or timeline.

4) Helping subgrantees invest in performance improvement and program effectiveness: The Foundation sees itself as a learning organization, modeling use of evaluation as corrective feedback to modify implementation of our initiatives over time. Foundation grantees are encouraged to plan for and conduct their own evaluations; in addition to on-site TA, the Foundation and CCHE offer an annual two-day evaluation workshop to Foundation grantees. In these trainings, grantees are grouped with others

implementing similar projects; they work together in small groups on their evaluation plans, which facilitates mutual learning. In 2010, CCHE and the Foundation are piloting an Evaluation Learning Collaborative: these bi-monthly conference calls offer grantees an opportunity to problem-solve and solicit feedback with peers; discuss the use of evaluation for program improvement and accountability; and share resources.

KHFI subgrantees will be required to develop an evaluation plan for their implementation project, and will receive similar comprehensive TA to do so.

In addition to TA on evaluation design, data will be made available to grantees through the Foundation's Kentucky Health Facts web site and other mechanisms. Grantees will receive TA in the use of these data from the Foundation, CCHE, and the Kentucky State Data Center (which houses the administration of the website and the Foundation's LDLA Program Officer).

5) The Foundation has a large pool of qualified individuals and firms with whom we enter into contractual agreements to provide capacity-building workshops for groups of subgrantees and subsequent site-specific TA. This combination, followed up with informal telephone conversations and site visits, has worked effectively to address shared and specific needs of subgrantees without undue imposition on their time and resources. For example, we engage the services of Prevention Institute to teach their ENACT and THRIVE models of community assessment and Drs. Wayne Myers and Forrest Calico to teach Community-Initiated Decision-Making. We are currently in negotiations with faculty from the Brushy Fork Institute to offer training on leadership and community consensus building. We have used and continue to use the services of the UK College of Agriculture/Extension Service and Crown Medical Management Inc, to teach topics in strategic planning, business planning, financial management and development of a financial pro forma. Kentucky Primary Care Association and Crown

have also been used to address grantee data management concerns. We have contracted with other firms to teach a range of communications skills, from specific messaging, to use of electronic and social media to reach constituency groups.

6) When subgrantees gather quarterly for Foundation-sponsored workshops, there is time built in to share information and approaches with other current subgrantees, and to learn from the experience of former grantees. Under some Foundation initiatives, these sessions are augmented with telephone exchanges and e-mail listservs.

As in the LDLA program, the Foundation will hold regular face-to-face convenings, teleconferences, and webinars involving all KHFI subgrantees (details above). These are invaluable for mutual learning among grantees, as best practices are shared and continuous quality improvement takes place. Subgrantees will also be required to participate in initiative-level evaluation, conducted by CCHE. In consultation with the Foundation and the Corporation, CCHE will disseminate evaluation findings, highlighting common themes from across grantee sites. These findings will be shared with the subgrantees so that they can learn from each other's experiences.

7) We are aware of the challenges that securing matching funds and ensuring sustainability represent in resource-poor areas of Kentucky, in the depths of a recession. The Foundation has a successful track record in assisting grantees to secure funds from other local community and family foundations and helping nonprofits pursue funding from larger national foundation funders. We help nonprofits develop their good ideas into bankable business plans, and are permitted under our investment guidelines to offer loan guarantees to grantees approaching local financial institutions for funds for capital equipment and construction in support of a program or project developed under a Foundation grant. We also encourage grantees to explore policy changes that will assure the sustainability of their efforts beyond

the life of the grant. For example, grantees that have helped their community adopt a smoke-free ordinance, or their schools to create and embrace a "farm to school" program to assure the availability of fresh produce for student meals, have assured sustainability of the gains they seek without large amounts of continuation funding.

8) Using data to measure performance and program effectiveness: The Foundation works closely with its grantees to identify areas for program improvement. These areas are identified through reports to the Foundation about progress on key activities and evaluation measures, and formative feedback from CCHE about areas where grantees could use more TA. As described above, the Foundation provides formative feedback to grantees based on data reported by grantees themselves. For example, in its first years of grantmaking, the Foundation found that grantees often had difficulty "ramping up" to receive a grant of $100,000 - $250,000 and using it to demonstrate effective innovations in a 12-month period; accordingly, we modified our initiative process to provide for a less costly planning year, followed by two or more years of implementation of the proposed demonstration project. Another ongoing evaluation of the Foundation's Coordinated School Health (CSH) Initiative demonstrated the importance of leadership support for the programs and policies to be implemented; this learning has lead to modifications in the annual CSH Institute, and an effort to engage the Kentucky School Board Association in shared commitment to key areas of school health policy change.

While some grantees move to replication and expansion in their second and third years of project funding, in other cases replication efforts are driven by the Foundation. For example, in the Foundation's Initiative for Integration of Mental Health and Medical Services, we have convened an Integrated Care Action Team to identify barriers to full implementation and changes to law and statute that would facilitate further implementation/replication. With TA from the National Academy for State Health Policy to identify best practices throughout the nation, the Foundation has developed an issue

brief, to use in discussing needed reforms with state-level health administrators. Learnings from this Initiative have also prompted the Foundation to make a University of Massachusetts distance learning certification program available to local grantees.

9) Accountability and metric: Bearing in mind that the aim of social innovation funding is to identify and elevate potentially transformative practices or approaches that can contribute to a Healthy Future for Kentuckians, the challenge of metrics in this work is to find a "next big thing" that can be replicated in other communities, addresses multiple social challenges concurrently, and/or produces significant cost savings/efficiency gains. And not to miss it, or be afraid of it, because it's different from what we've always done. For the Foundation, as intermediary, we want to be sure that we are casting the net wide enough: Are we reaching communities that have a long history of poor health and/or of limited health care access? For both intermediary and subgrantee, key metrics must address: Are we engaging the impacted communities in design of new products and approaches? Are the innovations adopted? Sustained? Do they have the intended health impacts? Specific measures will be identified once the subgrantees are chosen using a participatory process (discussed above). For example, if the health issue is obesity/nutrition/physical activity, a few measures might be:

Near term: Have we made fresh fruits and vegetables more accessible and affordable? Are they being purchased? Are they being used (self-report)? Is the business model to deliver them financially self-sustaining?

Long-term: Have we reduced the proportion of low-income children and teens in this community with a BMI consistent with obesity?

References

(1) United Health Foundation. America's Health Rankings: A Call to Action for Individuals & Their

Narratives

Communities. 2009. Available at:

http://www.americashealthrankings.org/2009/report/AHR2009%20Final%20Report.pdf.

(2) Centers for Disease Control and Prevention (CDC), National Center for Health Statistics, Division of Vital Statistics, National Vital Statistics Report Volume 58, Number 1, August 2009, Table 3. Available at http://www.cdc.gov/nchs/products/nvsr.htm#vol58.

(3) U.S. Cancer Statistics Working Group. United States Cancer Statistics: 1999-2006 Incidence and Mortality Web-based Report. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; 2010. Available at:

http://www.cdc.gov/uscs.

(4) CDC. Behavioral Risk Factor Surveillance System Data 2008. Available at

http://www.cdc.gov.brfss/.

(5) CDC. Behavioral Risk Factor Surveillance System Data 2006-2008 as analyzed by the UK Markey Cancer Control Program and College of Public Health. Available at http://www.kyhealthfacts.org.

(6) CDC. Behavioral Risk Factor Surveillance System Data 2008. Available at http://www.cdc.gov.brfss.

(7) CDC. Behavioral Risk Factor Surveillance System Data 2006-2008 as analyzed by the UK Markey Cancer Control Program and College of Public Health. Available at http://www.kyhealthfacts.org.

(8) SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004-2005.

(9) SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004-2005.

(10) U.S. Census Bureau (2000). Census 2000 Summary File 1.

(11) Center for Health Equity, Louisville Metro Public Health and Wellness. Available at

http://www.louisvilleky.gov/Health/equity/FoodJustice.htm.

(12) Glaser, B. (1992). Emergence vs. Forcing: Basics of Grounded Theory Analysis. Mill Valley, CA: Sociology Press.

(13) Beery, W. L., Senter, S., Cheadle, A., Greenwald, H. P., Pearson, D., Brousseau, R., Nelson, G.D. (2005). Evaluating the Legacy of Community Health Initiatives: A Conceptual Framework and Example

Narratives

From the California Wellness Foundation's Health Improvement Initiative. Am J Eval, 26(2), 150-165.

(14) Ottoson, J.M., Green, L.W., Beery, W.L., Senter, S.K., Cahill, C.L., Pearson, D.C., Greenwald, H.P., Hamre, R., Leviton, L. (2009). Policy-contribution assessment and field-building analysis of the Robert Wood Johnson Foundation's Active Living Research program. Am J Prev Med, 36(2Suppl 1):S34-S43.

(15) Greenwald, H. & Beery, B. Health for All: Making Community Collaboration Work. Chicago, IL: Health Administration Press.

Organizational Capacity

A. ABILITY TO PROVIDE PROGRAM OVERSIGHT

History of the Foundation:

In November 1996, the Kentucky Department of Insurance Commissioner and Attorney General began an investigation of the conversion of charitable assets of Blue Cross & Blue Shield to Anthem, Inc. as a result of their 1993 merger. In 1999 the parties reached agreement and Anthem provided $45 million to endow an independent charitable foundation with a mission to address the unmet health needs of Kentuckians. In the Fall of 2000, a 34-member CAC was named with members reflecting the geographic, gender, racial and ethnic diversity of Kentucky. The CAC developed Articles of Incorporation and Bylaws and proposed members of an initial Board of Directors, which held its inaugural meeting May 9, 2001.

As the Foundation began its first full year of operations in 2002, the Board and CAC conducted a series of listening workshops around the state that provided the basis for the Foundation's focus areas: health education and prevention programs focused on children and families, with special emphasis on fitness and nutrition, youth smoking and substance abuse prevention, and access to health services and care for all ages, with emphasis on low income, uninsured and rural populations.

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By 2006, the Foundation was fully operational, and the Board and CAC undertook a second strategic planning process that resulted in the 2007-2011 Strategic Plan under which we now operate. This Plan included continuation of Foundation Initiatives for Coordinated School Health; Primary Care and Integrating Mental Health and Medical Services. The aims of two new Initiative areas (LDLA and Community Health Advocacy) placed greater emphasis on increasing support for civic engagement. LDLA built on previously-funded data projects: a County-by-County Health Indicator Report (published in 2007 by the Kentucky Institute of Medicine) and the Kentucky Health Care Market Report; it added a user-friendly website (www.kyhealthfacts.org), provided support in local use of data for health planning and policy change, through a position funded at the State Data Center, and offered grant funding to communities undertaking health planning and policy change projects to find innovative ways to improve their communities.

In early 2008, the Foundation funded several grants under each of its active initiative areas including awarding LDLA grants to seven communities to plan for or implement projects to address an identified community health need. However, in the Fall of 2008, like many charitable organizations, the Foundation was hit by Wall Street volatility. The value of Foundation investments dropped below the "floor" which, per the Foundation's Articles of Incorporation, requires a sharp cutback in grantmaking. In response, Board and staff implemented a strategy to continue to advance the Foundation's mission, wherein all current grant commitments were honored and upheld and grantees whose work under a multiyear initiative was progressing satisfactorily continued to be eligible for funding. Health advocacy work continued. We continued to make available the best information we could provide, helping policymakers at the state and local level to "work smarter" in navigating these hard times. We continued to seek out partnerships with other funders in and outside the state, who share our interest in improving Kentucky's health. And we made efforts to connect our grantees with other resources to continue their work. We remained committed throughout this difficult time to the implementation of our 5-Year

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Strategic Plan, and to assuring that what we learned in each of these areas was translated into strategies for policy and programmatic change.

This strategy was maintained in 2009. No new grants were funded, though the Board respected our implicit and explicit commitments to communities working in good faith through our multi-phase initiative (amending our Articles of Incorporation to do so). By year's end we awarded more than $2 million in grants to existing grantee organizations, to continue their work in these challenging times.

By securing TA for grantees from local and nationally-known providers, and making their advice available not just to grantees but to other interested nonprofit organizations and communities, we have expanded the impact of our Initiatives, even in these budget-strapped times. Kentucky Primary Care Association, Crown Medical Management, Community Catalyst, the Public Policy Institute, the Prevention Institute, the Herndon Alliance, the Alliance for Justice, and the National Association of County and City Health Officials (NACCHO) are some of the advisors whose group workshops and one-on-one consultations have helped assure that health policy and health access work in Kentucky are built on the best information available.

In addition to grantmaking and TA, Foundation staff forged new relationships with partners in and outside the state to advance our mission: Collaborative Family Health Care Association, Kentucky Dietetic Association, Center for Health Equity and Kentucky's new state Office of Health Equity, Healthy Eating, Active Living Convergence (this effort is termed "Shaping Kentucky's Future" in the Commonwealth). At the same time, we respected and maintained our relationships with existing partners: CHFS, Leadership Kentucky, Kentucky Educational Television, UofL, UK, Public Welfare Foundation, Health Foundation of Greater Cincinnati, etc.

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Today, Foundation assets are well above the $45 million "floor" and we are making new grants in 2010. As this description of the Foundation's history shows, our mission is closely aligned with the Geographic - Healthy Futures aims of the Social Innovation Fund. The quest for local innovation in this arena most closely parallels our work in the Foundation's LDLA, Challenge Grant program and our Healthy Eating, Active Living program, "Shaping Kentucky's Future."

Some of the more striking accomplishments of Foundation grantees include:

1) Development of a model for in-home care of the frail elderly, which was "taken to scale" as a program of Kentucky government

2) A pilot e-prescribing program, also greatly expanded by the state, permitting rural medical groups and others serving low-income families to begin a migration to electronic medical records.

3) Development of innovative health services programs in the Magoffin and Todd County school systems, to provide enhanced access to primary care and dental care for low-income families with limited transportation.

4) Concerted efforts by trained Kentucky advocates, funded by the Foundation, contributed to the legislature's decision to double the tobacco tax in the 2009 legislative session, and to eliminate the face-to-face visit previously required to determine children's eligibility for Medicaid and CHIP.

5) The work of one grantee has resulted in more than a quarter of Kentucky residents now living in jurisdictions with smoke free restaurants, offices and public buildings.

Although the Foundation has not yet managed a federal grant, the Foundation's Executive Director has done so in previous executive positions in Arizona and California. The Foundation is presently managing subgrants received from the Public Welfare Foundation ($750,000) and is in discussions with the national Healthy Eating, Active Living Convergence and their agent PolicyLink to bring $150,000 to Kentucky to support "Shaping Kentucky's Future." The Foundation has clear and rigorously observed practices for competitive grant review and program monitoring, supported by GIFTS software tracking

capability and a program of regular site visits to grantees conducted by program staff and volunteers from the Board and CAC.

The Foundation's Executive Director has considerable past experience in program evaluation, having provided training to other foundations in this area, at both regional and national convenings. Believing in the value of an independent evaluation function, the Foundation has partnered with leading evaluation personnel and organizations involved in evaluation nationwide, and selected through a competitive bid process. Through these linkages, the Foundation has built internal understanding of evaluation among grantees and an ability of key decision-makers to critique and utilize evaluation methods and findings.

Since the Foundation embarked upon its grantmaking efforts, we have partnered with outside evaluation experts and organizations, like CCHE, who will be engaged to evaluate the Corporation grant. CCHE has particular expertise in the planning and evaluation of community-based health interventions and evaluation of multi-site programs. They have pioneered evaluation methods and published studies on their participatory evaluation and logic model case study approaches. CCHE serves a nationwide clientele, including foundations and government agencies. Final reports are not due until 2012 on the four multi-year evaluations CCHE is conducting for the Foundation; interim reports are available on request. In addition to identifying our current evaluation consultant through a nationwide competitive bid process; the Foundation assures the high technical standards and independence of the evaluation through the oversight provided by a national panel of experts on evaluation and health service delivery issues.

Evaluation findings are used internally by staff, and shared with the Foundation's Board and CAC Committees, which make recommendations to the Board regarding modification of programs and grant

initiatives. Examples of such modifications, cited previously, include the decision to move from single-year to multi-year funding in our major grantmaking initiatives, and more recently to retain expert consultation on communications to enhance dissemination of the work of the Foundation and our grantees. The Foundation's Primary Care Initiative was quite successful in developing and implementing a methodology to assist underserved rural areas of Kentucky in developing health and business plans and financial pro formas, and obtaining federal funding to start or expand federally-qualified health clinics. The model of training and TA used in this initiative contributed significantly to our ability to attract over $9 million in new clinic funding to the Commonwealth. In our Advocacy Initiative, we have provided financial support to the Center for Smoke-Free Policy, which has developed effective strategies for working with local jurisdictions to effect implementation of smoke-free workplace policies in cities and counties across the state. More often our work is in the development of demonstration projects/models, which are then replicated with funding from other sources.

The resources the Foundation makes available to assist subgrantees with replication or expansion include TA to develop rigorous business plans and a loan guarantee program. In addition, the Foundation has a small Matching Grant program, to provide mandated local match for nonprofits seeking to draw funding to Kentucky from national foundations that require such match. TA funded by the Foundation and provided by Kentucky Primary Care Association, UK/College of Agriculture Extension Service, Brushy Fork Institute and Crown Medical Management (among others) has already been mentioned.

As this brief history of the Foundation suggests, we have been supporting and overseeing multiple programs at sites throughout the state in all of our Initiative areas. We have continued to add and train program officers as needed; typically seasoned content experts and grants managers who gain further skill in grantmaking through training programs offered by Grantmakers in Health (GIH) and the

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Southeast Council of Foundations (SECF).

Given the number of grants the Foundation has made to health nonprofits in Kentucky since its inception, there is some likelihood that grant proposals will be received from organizations that are known to us, or that have been funded in the past. The Foundation networks regularly with other foundations, particularly those involved in health and wellness, and what is sometimes characterized as "healthy communities" or place-based philanthropy that seeks to address social determinants of health. Our Executive Director and managers are active participants in professional associations including GIH, the SECF and the American and Kentucky Public Health Associations. Our Executive Director is a member of the Kentucky Institute of Medicine. This has enabled us to create constructive partnerships with local, state and national foundations. Most recently, the Foundation brought together 12 foundations (corporate, family and community) in the state, who share our interest in nutrition and physical activity, to create "Shaping Kentucky's Future," committed to putting into practice policy recommendations in an issue brief of the same name sponsored by the Partnership for a Fit Kentucky. Regardless of our relationships with other funders and potential grantees, the Foundation's proposal solicitation and review processes have been created to assure a "level playing field" for all applicants and consideration of all proposals on their merits.

The Foundation monitors site compliance with programmatic requirements through desk review of documentation submitted by subgrantees, site visits to each funded program by Foundation staff and volunteers, the provision of TA by content experts, and conduct of an external evaluation. The Foundation reserves the right to conduct financial audits of use of grant funds, with the books to be made available during working hours at subgrantee sites.

Board of Directors, Administrators and Staff: The Foundation is governed by a fifteen member Board of

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Directors, with added oversight provided by a 31-member CAC (which appoints the majority of the Board). Board and CAC members may serve up to two consecutive three-year terms. Orientation of new members is provided annually in February; in addition, the Executive Director meets individually with each new member, to answer questions and further introduce the work of the Foundation. There is a program staff of five: the Executive Director, the Program Manager and three Program Officers (one of whom is under contract to the Foundation and housed at the State Data Center). In addition there is an administrative and program support position; CPA service is contracted with a firm located nearby, and the Foundations books are audited annually by the State Auditor's office.

Two Foundation committees (made up of both Board and CAC members) are involved in program oversight: The Program Development and Oversight Committee helps craft Initiative parameters and oversees initiative execution; they review the evaluation reports and make recommendations to the Board regarding program modifications. The Grants Committee reviews proposals submitted under each Initiative and, with staff and technical experts, conducts site visits of all grants of $100,000 or more prior to making funding recommendations to the Board.

Brief bios of key Foundation staff:

SUSAN G. ZEPEDA is Executive Director of the Foundation. Before joining the Foundation in 2005, she was the first CEO of The HealthCare Foundation for Orange County (1999-2005) and, prior to that, Director of the San Luis Obispo County (CA) Health Agency and CEO of that County's General Hospital. Earlier, she was Executive Director of a consortium of nonprofit healthcare providers in Tucson, Arizona. Dr. Zepeda is on the Board of the Kentucky Institute of Medicine. Prior civic service has included the Boards of GIH, NACCHO (Chair, Environmental Health Task Force); County Health Executives Association (Vice President/Chair of Legislative Committee); Hospital Council of the Central Coast (Chair); Rotary Club (Club President, 2001, 2004); City Planning Commission. She holds degrees

from Brown University, University of Arizona and International College, and has completed the CDC-sponsored Public Health Leadership Institute and Harvard University's Program on Negotiation for Senior Executives.

MARY JO DIKE has been with the Foundation since 2001. In her role as Program Manager, Ms. Dike manages daily operations including accounting and audit functions, and communications. In addition, she has served as lead staff to the Foundation's Community Grants Program, Integrated Services Initiative and the annual Howard L. Bost Memorial Health Policy Forum. Prior to coming to the Foundation, Ms. Dike was an Information Analyst for a Louisville based computer software development company. Prior to that she worked as Program and Services Director for the Kentucky Psychological Association. Mary Jo Dike has an undergraduate degree in Psychology and a MBA from Bellarmine University in Louisville.

JOAN BUCHAR is Senior Program Officer with responsibility for the Foundation's Health Advocacy and CSH Initiatives. Prior to coming to the Foundation she was Education Coordinator for the Purchase Area Health Education Center at Murray State University. Ms. Buchar has a bachelor's degree and a master's of education from Southern Illinois University. She also has completed a Master's in Public Health from Western Kentucky University and is currently a PhD candidate in Public Health at the UofL.

SARAH WALSH is Program Officer with responsibility for the Foundation's LDLA Initiative, and oversight of key data efforts, including management of the www.kyhealthfacts.org website (Ms. Walsh's position is housed externally at the Kentucky State Data Center at the UofL). Prior to joining the Data Center, she was a Cancer Control Specialist with the Kentucky Cancer Program. Ms. Walsh holds a bachelor's degree from the University of Michigan and a master's degree from Boston University's

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School of Public Health. She is currently pursuing her PhD in health promotion at the UofL.

Recruitment is currently underway for an additional Program Officer/Policy Analyst whose duties will include support of the Foundation's Primary Care Initiative and staffing the Rural Health Redesign task force assisting the Foundation in moving that Initiative from demonstration projects to policy change proposals. This position, to be filled by mid-April 2010, will be responsible for researching and analyzing various population health and health care issues; preparing reports and articles; and educating and training policymakers and the general public.

It is expected that one additional Program Officer will be named, to support KHFI if funding is received.

In addition to in-house orientation to Foundation policies and procedures, new Program Officers are provided with further training through the Art and Science of Grantmaking program offered by GIH and similar offerings of the SECF. To keep skills and knowledge current, program staff capitalize annually on training opportunities relevant to the content areas in which they work.

The Foundation views itself as a learning organization and regularly employs the following internal assessments

1) an annual web survey of all Board and CAC members, to assess the performance of the Executive Director, and annual reviews are conducted of staff performance and scope of work

2) staff meet weekly to discuss areas of intersection in our respective areas of work, and to identify opportunities for streamlining Foundation work

3) staff hold monthly conference calls with external TA providers for each Initiative, to assure that all are kept apprised of current developments

4) biennial self assessments of Board and CAC performance are completed, analyzed and discussed by

the respective bodies with recommendations for future modifications

5) web surveys are made of all grant applicants (whether successful or not) regarding their experience with the Foundation, application processes, and staff.

6) The PD+O of the Board meets quarterly with staff to review the performance of Foundation Initiatives and make recommendations to the Board regarding future directions.

7) The Foundation's Strategic and Policy Direction Committee (consisting of all members of the PD+O and Advocacy Ambassador Committees of the Board and CAC as well as the officers of both Board and CAC) meets each August to review the Foundation's performance for the year to-date, and progress in Initiatives, and to make policy recommendations for the Annual Operating Plan and Budget to be developed for the new calendar year. The budget and scope of work for the new year will drive staffing considerations; in 2010, these included addition of one FTE Program Officer and an external communications team.

8) Key vendor relations are reviewed and re-bid every three to five years. Software and support systems are also reviewed and upgraded as needed: in late 2009, the Foundation upgraded its server system and software, and further enhanced the ability of all staff to work from remote sites.

B. ABILITY TO PROVIDE FISCAL OVERSIGHT

The Foundation is an existing grantmaking organization with a solid track record of investing in nonprofit community organizations as a core means of fulfilling our mission, to address the unmet health needs of Kentuckians. Board-approved policies and procedures govern the manner in which we conduct open, competitive processes under each of the Foundation's Initiatives to award grants to qualified community nonprofit organizations; negotiate specific grant requirements; and oversee and monitor performance of grantees.

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In addition to in-house Foundation staff, we have external support from the CPA firm DMLO, well-versed in requirements for nonprofit and federal grant accounting. We are audited by the State auditor, who is also fully familiar with governmental accounting requirements and available to provide consultation as needed. In prior positions the Foundation's Executive Director had responsibility for oversight of federal grants and subgrantees. Foundation TA providers, such as the Kentucky Primary Care Association, also have experience in training grantees in the record-keeping and oversight required for satisfactory implementation of federally-funded grants.

The Foundation's infrastructure is designed to support the management of a significant grants program, with grants of $2 million to $2.5 million per year. Grants tracking support is offered through our Administrative Support staff, GIFTS software, and a team of Program Officers each managing a portfolio of grants in their Initiative area.

Our current organizational budget of over $3.4 million includes operational programs of training and TA and targeted policy analysis, as well as an anticipated $2.5 million in grants under the Foundation's five initiatives. Receipt of the SIF award of $1 million from the Corporation for National and Community Service would increase the budget to $4.4 million - the grant requested would then represent 23% of the Foundation's budget.

We will adhere closely to the requirements of the SIF grant, working closely with Corporation staff, and local advisors as needed, to assure compliance with all terms of the Social Innovation Fund award.

Budget/Cost Effectiveness

A. BUDGET AND PROGRAM DESIGN

The Foundation's budget and the proposed match for SIF are from our endowment. Although we have

attracted grants from the Public Welfare Foundation ($750,000) and doubled resources to communities through a Challenge Grant program matching community foundation funds with Foundation funds, we do not usually pursue external grants. As one of very few grantmaking entities in Kentucky with the resources to match the SIF requirements, we have chosen to pursue this opportunity. In addition to the required match for SIF, the Foundation will allocate staff time, communications support, and training resources in support of KHFI and its subgrantees. The supportive framework we create for grantees is essential in reaching out to, and engaging, the significantly philanthropically underserved communities in which we work.

B. MATCH SOURCES

With SIF and Foundation matching funds, augmented by access to other Foundation resources, we will fully support the proposed KHFI. In addition to the $1,640,000 to be subgranted, the $2,000,000/yr in KHFI funding will be used for:

1) RFP design, in consultation with Corporation as needed.

2) Dissemination of RFP; provision of a webinar for prospective applicants, to clarify proposal requirements, with frequently-asked questions subsequently posted on the Foundation's website.

3) Site visits to all applicants, prior to Grants Committee deliberations, with added expert technical review as needed.

4) Staffing the grant review process, at the Grant Committee and Board level.

5) Training and TA for grantees during the grant period; on-site monitoring and desk review of subgrantee work products.

6) External evaluation of KHFI and program outcomes.

The Foundation is provisionally requesting $11,600 in indirect costs (calculated at a rate of 29% of direct

costs). These costs will also be matched on a 1:1 basis by the Foundation.

Clarification Summary

The Foundation is grateful for the opportunity to provide additional clarification to our Kentucky Health Futures Initiative (KHFI) SIG application.

PROGRAMMATIC CLARIFICATION

1. Over the SIF grant period (five years), the Foundation will provide tailored and intensive technical assistance to ensure that our subgrantees develop the capacity to replicate and expand successful programs. Provided through workshops and one-on-one follow-up with subject matter experts, this technical assistance will emphasize the skills subgrantees need to (a) carefully document the manner in which the program is implemented; (b) rigorously evaluate its impact; (c) develop a viable business plan that clearly identifies expenditures and sources of needed revenue; and (d) work effectively with advocacy partners to ensure a legislative and regulatory environment supportive of project replication or expansion.

As one example of the added value we bring to grantmaking, in the Foundation's current initiative for integration of mental health and medical services, we have worked with subgrantees to identify changes to regulation, reimbursement practices and the state's Medicaid plan that will make it easier to replicate integrated service models and are now working with statewide professional associations and the Cabinet for Health and Family Services to advance these changes.

Whether or not legislative solutions are needed, all KHFI subgrantees will develop a financially self-sustaining business plan for their program. This will ensure the long-term sustainability of the project and provide communities with a tool they can take to banks, investors, or other funders to secure

investments needed for replication and scaling.

2. As part of our commitment to building the evidence base for effective programs, the Foundation and the Center for Community Health and Evaluation (CCHE) will provide technical assistance -- in collaboration with local university faculty -- to increase the scientific rigor of subgrantee evaluations. We will work with subgrantees to establish "moderate" evidence, as defined by the Corporation, for the impact of their programs. While randomized controlled trials are not anticipated, we will work with subgrantees to identify comparison groups for quasi-experimental studies and to use time series analysis to permit the target group itself (prior to project implementation) to serve as a control group. In time and with replication, this will position us to produce "strong" evidence in support of subgrantees' work.

For example, with a model program to provide school-based primary care services in a low-income community, we would assist the subgrantee to evaluate the proportion of students receiving Early Periodic Screening, Diagnosis, and Treatment services (well child exams); health status on EPSDT exams; hospital emergency room visits for ambulatory sensitive conditions such as asthma; as well as rates of absenteeism, and other targeted measures for the population prior to and during project implementation, and compare these findings with data from a comparable school district's population where the project has not been implemented.

3. The Barren River District Health Department (BRDHD) was pre-selected as a subgrantee through a competitive grant application process under the Foundation's Local Data for Local Action Initiative. They were selected based on their organizational capacity, sound methodological approach to community health improvement planning, and their track record of successful collaboration with key community stakeholders. Having been competitively selected to participate in an initial planning

period, during which training and technical assistance were provided, and having developed an evidence-based solution to a community health need and a financially sustainable business plan, BRDHD was eligible to apply (again, through a competitive selection process) for implementation funding.

This community faces several oral health challenges. The number of practicing dentists in the Barren River District is well below state and national averages relative to its population (Peterson, Williams, & Mundt, 2007). Of those who do practice in the community, many do not accept Medicaid, are closed to new patients or otherwise present barriers to the low income and underserved residents of the community. Finally, community social norms place little value on preventive oral health services despite high rates of tooth loss and other indicators of need (Kentucky Institute of Medicine, 2007).

Their proposed solution strategy was designed to improve access to preventative and restorative dental services in the community, increase demand for oral health services by changing social norms, and increase the number of dental providers in the area. The Barren River District Health Department was funded to implement a comprehensive community dental program in four Kentucky counties. As the program becomes financially self-sustaining, BRDHD plans to expand into four additional counties in the next two years.

Key project activities include establishing and staffing a Dental Services Branch at BRDHD, launching an intensive oral health campaign in local schools, daycares, preschools and Head Start centers. Through this campaign, project staff will provide group education services to 7000 residents, and provide fluoride varnishes and preventive treatment for at least 800 residents in their first year. In addition to the prevention and screening services provided, BRDHD has established a referral network of dentists to provide restorative treatment, regardless of an individual's ability to pay.

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To increase access to care, the use of a mobile dental unit was proposed as a financially viable and self-sustaining option (Arevalo, Chattopadhyay, Lester, & Skelton, 2009). To further ensure sustainability, BRDHD planned to launch their program using a van and portable equipment. A mobile unit would be added towards the end of the first program year, once the program started to generate revenue.

The preliminary evidence of impact of their proposed intervention for provision of oral health services using a mobile dental clinic was based on the findings of other safety net dental programs offered in Kentucky and elsewhere (Brooks, et al., 2002; Carr, Isong, & Weintraub, 2008; Diaz-Perez Mde, Farley, & Cabanis, 2004; Griffith, 2003; Jackson, et al., 2007; Werner, Gragg, & Geurink, 2000). These similar programs have been shown to increase service delivery, reduce missed appointments, and increase patient satisfaction. While little information is available in the literature on the overall health impact of mobile dental programs, often, measures of increased access to care, and/or service satisfaction have been used as a proxy for improved oral health.

For example, Brooks et al (2002) evaluated patient satisfaction with the Elk Mobile Dental Program, which has been serving children with special health care needs in Missouri since 1962. Patient surveys indicated high levels of satisfaction with the services provided by the Elk Mobile Dental Program and a need for more permanent services in the community. This supports BRDHD's plan to provide mobile services as well as their long-term plans to attract more oral health providers to the service area through increased demand.

Carr, Isong and Weintraub (2008) surveyed directors of 33 mobile dental programs in California. The identified programs served predominantly low-income, school-aged children, many of whom are Medicaid-eligible. This is similar to the target population identified by BRDHD. Survey responses

indicated that, absent the mobile dental programs, it would be "very difficult" or "difficult" for the target population to obtain services.

Jackson et al (2007) evaluated the St. David's Dental Program, which utilizes mobile dental units to serve a 2-county region in Texas. In one year, the program was able to provide $2.1 million worth of services (including education, sealants, screening and other treatment services) at a cost of just $1.2 million. They attribute the success of this program to the staff and the efforts made to obtain consent forms from nearly all of the parents in the school district.

Another Texas mobile dental program was evaluated by Werner, Gragg and Geurink (2000). They found high rates of satisfaction among the dental practitioners and students who provided the services on the mobile units. The mobile programs increased community awareness of the dental resources available in the community, contributing to the type of cultural change that BRDHD is hoping to achieve.

While the body of scientific literature is limited, collectively, these studies provide an evidenced-based framework for the work BRDHD is undertaking. As may be seen from the works cited, the research generally posits that improved access to dental care results in improved clinical oral health outcomes, and focuses more on patient access to and acceptance of services, numbers of services provided, and financial viability.

There is considerably more evidence to support the impact of the services that will be provided through the BRDHD mobile program. Based on their systematic review of the available literature, the Task Force on Community Preventive Services recommends school-based sealant programs, such as will be offered by the BRDHD program, as an intervention to prevent dental caries (2002). On average, the use

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of sealants leads to a 60% decrease in dental caries on the molars and pre-molars of children. Systematic reviews of another proposed service suggest that the use of topical fluoride varnish can prevent 46% of tooth decay (as measured by decayed/missing/filled surfaces) in children (Marinho, 2008).

BRDHD is expected to contribute to this body of literature and generate "moderate evidence" of the impact of oral health outreach and mobile service delivery on health outcomes and social norms. Their initial evaluation plan will demonstrate the financial sustainability of the project, changes in the number of providers, community support for the program, and oral health outcomes for their service population.

The Year One Budget for this project was $731,821.00. Of this amount, BRDHD anticipates generating $210,000 in revenue (insurance reimbursements), the Foundation has committed $250,000, and the remaining $271,821 will be provided through matching funds from the BRDHD and their community partners.

Budget categories include:
Salaries and Benefits: $209,822 (including a newly hired Dental Branch Manager).
Independent Contract Employees: $6,698 (local dentists to provide restorative services as needed).
Direct Costs: $448,772 (most significantly, this includes equipment for a mobile operatory, a $250,000 mobile dental unit and a $50,000 Dodge Sprinter van. These capital expenses will be paid for with BRDHD funds or revenue generated by the program. While the Foundation will not pay for capital expenses, we did accept them as part of the community match).
Indirect Costs (10% of direct costs): 66,529.

We would be happy to furnish a copy of the BRDHD's full proposal and line item budget upon request.

Narratives

References:

Arevalo, O., Chattopadhyay, A., Lester, H., & Skelton, J. (2009). Mobile dental operations: capital budgeting and long-term viability. Journal of Public Health Dentistry, 70(1), 28-34.

Brooks, C., Miller, L. C., Dane, J., Perkins, D., Bullock, L., Libbus, M. K., et al. (2002). Program evaluation of mobile dental services for children with special health care needs. Special Care in Dentistry, 22(4), 156-160.

Carr, B. R., Isong, U., & Weintraub, J. A. (2008). Identification and description of mobile dental programs--a brief communication. Journal of Public Health Dentistry, 68(4), 234-237.

Diaz-Perez Mde, J., Farley, T., & Cabanis, C. M. (2004). A program to improve access to health care among Mexican immigrants in rural Colorado. Journal of Rural Health, 20(3), 258-264.

Griffith, J. (2003). Establishing a dental practice in a rural, low-income county health department. Journal of Public Health Management & Practice, 9(6), 538-541.

Jackson, D. M., Jahnke, L. R., Kerber, L., Nyer, G., Siemens, K., & Clark, C. (2007). Creating a successful school-based mobile dental program. Journal of School Health, 77(1), 1-6.

Kentucky Institute of Medicine (2007). The Health of Kentucky: A County Assessment. Lexington, KY.

Marinho, V. C. (2008). Evidence-based effectiveness of topical fluorides. Advances in Dental Research, 20(1), 3-7.

Peterson, M., Williams, J., & Mundt, C. (2007). Kentucky Dental Provider Workforce Analysis: 1998-2006 Retrieved September 2008, from http://chfs.ky.gov

Task Force on Community Preventive Services. (2002). Recommendations on selected interventions to prevent dental caries, oral and pharyngeal cancers, and sports-related craniofacial injuries. American Journal of Preventive Medicine, 23(1S), 16-20.

Werner, C. W., Gragg, P. P., & Geurink, K. M. (2000). The facilitating role of mobile dental van programs in promoting professional dental education. Brazilian Dental Journal, 11(2), 127-133.

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4. The Foundation selected the Center for Community Health and Evaluation through a national search (Request for Qualifications process) for an evaluation team with experience in the evaluation of multi-year community initiatives. We and they are committed to an approach to evaluation that is both rigorous and respectful of the entities, programs and populations to be evaluated.

As a condition of their selection, the Foundation requires CCHE to work with local evaluation experts, Dr. Muriel Harris with the University of Louisville and Dr. William Pfeifle with the University of Kentucky. We feel that this partnership has increased the evaluation capacity within the state. As evidence of this increased capacity, Dr. Harris will lead the evaluation team on a $7.9 million Communities Putting Prevention to Work grant recently awarded to the Louisville Metro Department of Public Health and Wellness by the Department for Health and Human Services.

Further, CCHE's work is overseen by a national advisory committee consisting of persons with evaluation expertise and with expertise on delivery of health services in Kentucky and elsewhere. We augment the expertise of this team by contracting for the services of other evaluators, researchers and epidemiologists to help guide and shape our evaluation strategies. This network will be leveraged to provide intensive support and technical assistance to subgrantees.

5. The Foundation uses a logic model framework to guide our work towards short and long-term outcomes. This framework permits us to identify the pathways and track processes to maximize results. While the specific indicators used to assess health impact will vary based on the project selected by the subgrantee, the framework for evaluating that impact will be the same. Subgrantees will be responsible for reporting their activities and outputs as process measures of successful implementation. Primary and secondary data collection will be used to measure the short term and long term impact resulting

from project implementation. With the example of a model school-based primary care program mentioned above, we would expect to see documentation of the number of student-clinician encounters, participation rates for educational programs on healthy lifestyles, the proportion of the student body served by the program, and reimbursement rates as process measures indicating that the subgrantee was adhering to their proposed workplan. These process measures should logically lead to short-term outcomes including increased numbers of students receiving well-child exams and other preventive services. In the long-term, we would expect that these services would lead to a healthier student body as measured by health status in the screening process (for example, decreased BMI); reduction in hospital visits for ambulatory-sensitive conditions such as asthma, reduced absenteeism and improved test scores.

6. The Magoffin County and Todd County school-based clinic sites are gathering data on the numbers of patient encounters provided, the proportion of the student population availing themselves of these services (penetration rates), health status of students served, and school attendance/absenteeism as compared to the health status and school attendance data for students at the same schools in prior years. Both projects are in the earliest stages of implementation and, although measurement mechanisms are put in place for outcome evaluation as the projects proceed, greater emphasis in the earliest months of implementation has been placed on accurately describing the nature of the intervention, to permit replication if it proves successful (using the short-and long-term outcome measures noted).

Non-smoking ordinances implemented in Kentucky jurisdictions are also still quite new; measures of their immediate impact include compliance assessment (records of reported violations; tests of the levels of smoke in venues before and after becoming smoke-free); the Foundation tracks smoking and lung cancer data at the county level, permitting cross-county comparisons over time, to assess the long-

term impact of this intervention. While some confounding variables can be controlled for -- such as price increases due to changes in state and federal excise taxes on cigarettes -- other behavioral dimensions are far more difficult to ascertain and control.

7. The Board-approved job description for a Program Officer requires that the individual hired to staff this project will possess a Master's or other relevant advanced degree with strong communication skills and relevant knowledge of the health issues facing Kentuckians. Specifically for this project, we will seek a candidate with a strong background in evaluation and program planning.

8. Foundation resources dedicated to KHFI are resources from the Foundation's endowment not being used for the funding of current projects or projects expected to be awarded grant funds in the course of our planned 2010 grantmaking. These unused resources are identified (in 2010 only) as coming from the funding category that includes Local Data for Local Action grants. This has permitted rapid response to the SIF opportunity. If our application is successful, future years' funds will have their own budget category and designation. SIF funds will not supplant Foundation funds, but will permit a significant expansion of resources dedicated to support implementation, documentation, evaluation and replication of innovative community-based strategies for improving the health of Kentuckians. If funded, participation in the SIF would increase both the Foundation's total grantmaking for the year (using both SIF and Foundation funds) and the absolute value of Foundation funds granted in 2010, by the award of new grants that would not otherwise have been awarded. New KHFI subgrantees will receive both Foundation funds and SIF funds.

9. No SIF funds or Foundation funds will be used to fund capital construction. The Foundation's grantmaking guidelines explicitly preclude capital expenditures. However, the Foundation's investment

guidelines include a form of mission-related investing whereby the Foundation is able to stand in second position as a loan guarantor when innovative programs and projects seek access to capital through local banks of community development financing institutions.

10. Subgrantees will be required to have a well-developed evaluation plan that is developed in tandem with their project implementation plan during the first months of the first funding year. The specific number of months required to develop both the evaluation plan and the project implementation plan will vary with the complexity of the project, the need for human subjects review, and the skill levels of the subgrantee. Completion and approval of a rigorous evaluation plan would be a requirement for further funding. The Foundation solicits input from expert reviewers on the evaluation plans -- including but not limited to the evaluation experts at CCHE and local universities. The assessment of the external reviewers is given significant weight in the deliberations of the Foundation Grants Committee, as it makes recommendations to the full Board regarding further funding. Additional oversight comes from the Program Development and Oversight Committee of the Foundation, who will review the evaluation and overall progress of the KHFI initiative as a whole.

11. Because many organizations doing good things for Kentucky lack the capacity or experience to apply for large grants in excess of $100,000, the Foundation has incorporated a planning phase into most of our initiatives. This initial year of KHFI funding will draw on our learnings from other initiatives to incorporate specific training and technical assistance on identifying community priorities, bringing together an effective project planning and design team, developing a viable business plan for project implementation, and design of a rigorous evaluation of processes and short-term and long-term outcomes and impacts. As previously noted, at the conclusion of this planning period, subgrantees will need to produce a well-developed evaluation plan and a sustainable business plan in order to receive the

remainder of their first year funds. At the conclusion of the first funding year, if the grantee has developed sound evaluation and project implementation plans, and demonstrated sufficient capacity to implement them, additional implementation funding is awarded. This stepped or phased approach controls execution-related risk for the grantmakers while imparting skills to respond to future funding opportunities in a community.

Ultimately, the Foundation is a learning organization and committed to continuous quality improvement. In subsequent years, the training and technical assistance provided to each cohort of subgrantees will be developed based on subgrantee feedback and external assessment of (a) the effectiveness of the training provided and of (b) skills areas that need to be emphasized in the second year of funding and beyond for the first cohort of subgrantees. These same sources of input will be used to modify and enhance the year 1 training approaches for subsequent cohorts of grantees.

12. The Foundation is a small organization, and if funded, KHFI would represent a significant increase in our grantmaking portfolio. While our Executive Director has considerable experience managing larger grantmaking and operational organizations, we recognize the need to expand our operational support capacity. To accommodate this, the Foundation is prepared to increase our staff size with the addition of a dedicated Program Officer; expand our evaluation relationships (leveraging our partnerships with university faculty in the state); and increase the hours of accounting support purchased from our CPA firm.

BUDGET CLARIFICATION

In light of our consideration for a two-year grant, we have amended our budget to include projected year

two costs for each line item. This increases our total grant request to $2,023,200.00 for the two years. We will provide at least 1:1 match for the full two year grant.

1. The Foundation does not have a federally-approved indirect cost agreement at this time, but we are prepared to work with the Corporation to identify an appropriate rate. We have provisionally calculated the indirect costs for KHFI at 29% of direct costs. This percentage was selected as most nearly matching Foundation estimates of true costs.

In 2010, the Foundation budgeted approximately $119,000 for professional services, rental of office space, insurance, website maintenance, telephone and internet service, office machines and supplies, etc. Allocated as a percentage of staff effort, the 1.2 FTE associated with the KHFI project would represent 20% of the Foundation's internal staff. Therefore approximately 20% of operations costs, or $23,800, was targeted as the annual indirect costs for this project.

2. The Scope of Work for the external evaluation provided by CCHE includes (a) refining the logic model, evaluation questions and indicators for KHFI; (b) convening a national advisory committee of experts to help guide the evaluation; (c) increasing capacity in Kentucky to conduct community-based evaluation for future initiatives; (d) providing technical assistance to grantees to build capacity for self-evaluation; (e) collecting data on subgrantee processes and outcomes through document review, key informant interviews, and subgrantee interviews, surveys, and site visits; (f) analyzing data; and (g) communicating findings through reports, presentations and formative feedback.

At present, the Foundation has a $225,000 agreement with CCHE to evaluate our current initiatives. Major cost centers under this agreement include salaries and benefits for evaluators and support staff ($125,535 for a total of 1.4 FTE); travel ($13,000); other direct costs ($11,465); subcontracts with

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Kentucky evaluators ($60,000); and indirect costs ($15,000 at 10% of direct costs). Allocations for the future work proposed under SIF are anticipated to be proportionally similar.

3. During the first year of the project, we are proposing a series of 4 technical assistance workshops at a total cost of $48,000. This would include $5000 honoraria for each of 2 expert presenters at each workshop ($5000 x 2 speakers x 4 workshops = $40,000). These honoraria will cover the presenters' travel costs and a commitment of their time after the workshops to provide one on one technical assistance to subgrantees. Room rental, equipment fees and catering for each 2-day workshop is estimated at $2000 ($8000 total).

During the second year of the project, we anticipate repeating this series of 4 workshops for the new cohort of subgrantees that will come on board. We will also provide 2 workshops to second year subgrantees. The total cost for these 6 workshops is projected to be $72,000.

4. The line item for Grantee, Staff, and Board Travel covers the costs associated with subgrantee participation in technical assistance workshops and staff and board member travel to site visit subgrantees. Mileage for all trips will be reimbursed at the federal rate (currently $0.50/mile).

Staff and Board travel: $2,000.

Foundation staff and/or Board members will site visit each subgrantee prior to awarding funds and at least once per year following implementation. We estimate this will result in 20-30 staff and Board trips per year (30 trips x an average of 100 miles roundtrip x $0.50 per mile = $1500). An additional $500 is projected for overnight stays for staff and Board members when subgrantees are more distantly located.

Subgrantee travel: $18,000.

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Subgrantees will be expected to send 2-3 representatives to four 2-day workshops. We estimate the costs of their travel to be $180 per person per workshop (hotel accommodations, mileage, meals and incidentals). This is the projected cost for approximately 25 participants to attend each of the 4 technical assistance workshops.

5. Criminal History Checks

The Corporation Designated Repository Agency for Kentucky, the Kentucky State Police, charges a fee of $20 for each criminal history check. The Corporation has also approved the Kentucky Administrative Office of the Courts (AOC) as an alternate. The AOC fee is $15 for each background check fee. We estimate that as many as 75 background checks would be required in the first year of the project (approximately 5 staff members for each of 12 subgrantees, plus key staff at the Foundation and CCHE) and an additional 50 background checks would be required in year two (allowing for a second cohort of grantees and any staffing turnover). Using AOC pricing, $1125.00 for year one and $750.00 for year two has been added to the budget to cover the costs of criminal history checks.

Required Documents

Document Name	Status
Match Verification	Sent

2010 Social Innovation Fund

Foundation for a Healthy Kentucky

Section 2 – Clarification Questions

Round 1 Clarification Questions:

1. Over your SIF grant period (five years), how will you work to ensure that your subgrantees develop the capacity to replicate and expand?
2. Please describe the specific criteria or manner in which "strong" or "moderate" evidence of program effectiveness will be judged or assessed. In doing so, please provide a concrete example of how you would assess a subgrantee's effect on long-term outcomes (include what type of evidence you would look at, and what statistical approach and research design would be used).
3. On page 14 you describe a pre-selected subgrantee called the Barren River Health District. Please provide information about how this subgrantee has "preliminary" evidence of impact and how they were competitively pre-selected.
4. You rely heavily on one organization (the Center for Community and Health Evaluation) for evaluation assistance. How will you engage other diverse perspectives around how best to evaluate your subgrantees? Are there other in-state resources to leverage?
5. On page 8 you list a few health impact outcomes that will be assessed. Please provide greater detail about the potential health impact outcomes you will likely assess through your work with subgrantees. In your discussion, describe what baseline data you have and how you propose to set realistic short-term, intermediate and long-term goals.
6. On page 30 you list a host of grantee accomplishments, but fail to describe the impact on health outcomes of this work. Please provide this information. For example, how significantly was access to health care improved in the Magoffin and Todd County school systems and what was the impact on health outcomes?
7. What qualifications will you seek in the Program Officer to be hired for your SIF?
8. You note that your match funds will come from LDLA funds in year one of your SIF. Does this mean your total grantmaking budget will only increase by the amount of Federal funds being subgranted?
9. On page 6 you note that subgrants in later years may be used to fund loans and "capital construction and equipment." What is your justification for this approach? Do you have a track record of making loans for such activities?
10. At what point (along a continuum of application to end of their grant period) will subgrantees be required to have a well-developed plan for evaluation? How will you leverage your governance structure to formalize approval of evaluation plans and ensure high-quality and consistency across your portfolio?
11. On page 24 you note that your grantees often had difficulty "ramping up". How have you incorporated this learning into your program design plans for year one versus subsequent years?
12. Explain two or three of the most significant organizational capacity challenges you expect to face with a SIF grant and how you propose to overcome them.

Budget Clarification:

1. Please provide a copy of your indirect cost rate agreement supporting the 29% claimed in the application.

2. Provide more detail and a breakdown of components included in the $200,000 budgeted for External Evaluation.
3. Provide a breakdown of components included in the $48,000 for Technical Assistance Workshops.
4. Provide a breakdown of components included in the $20,000 for Grantee, Staff and Board Travel.

Round 2 Clarification Questions:
1. You have provided insufficient evidence to support the pre-selection of Barren River in your response to clarification question #3. Please provide for our review, evidence of the effectiveness of the program model they propose to replicate, what definition of evidence in the SIF NOFA the program meets, Barren River's Year 1 budget, a description of the activities they propose to undertake, the impact they propose to achieve, their broad plans for evaluation, and, their qualifications to replicate the initiative.

Budget Clarification
1. Please note that a special condition will be placed on your award, should you receive one, because your indirect cost rate is provisional and will need to be formally approved. No action is required at this time.

2010 Social Innovation Fund

Foundation for a Healthy Kentucky

Section 3 – Budget

Kentucky Healthy Futures Initiative

Foundation for a Healthy Kentucky

Application ID: 10SI116273 **Budget Dates:** 08/01/2010 - 07/31/2012

		Total Amt	CNCS Share	Grantee Share
Section I. Program Costs				
A. Project Personnel Expenses		140,425	70,212	70,213
B. Personnel Fringe Benefits		42,128	21,064	21,064
FICA		0	0	0
Health Insurance		0	0	0
Retirement		0	0	0
Life Insurance		0	0	0
	Total	$42,128	$21,064	$21,064
C. Travel		50,000	25,000	25,000
D. Equipment				
E. Supplies		2,950	1,475	1,475
F. Contractual and Consultant Services		520,000	260,000	260,000
H. Other Costs		1,875	938	937
Subgrants		3,242,622	1,621,311	1,621,311
	Total	$3,244,497	$1,622,249	$1,622,248
Section I. Subtotal		**$4,000,000**	**$2,000,000**	**$2,000,000**
Section II. Indirect Costs				
J. Federally Approved Indirect Cost Rate				
Indirect Costs		46,400	23,200	23,200
	Total	$46,400	$23,200	$23,200
Section II. Subtotal		**$46,400**	**$23,200**	**$23,200**
Budget Totals		**$4,046,400**	**$2,023,200**	**$2,023,200**
Funding Percentages			**50%**	**50%**
Required Match			**n/a**	
# of years Receiving CNCS Funds			**n/a**	

2010 Social Innovation Fund

Foundation for a Healthy Kentucky

Section 4 – Budget Narrative

Budget Narrative: Kentucky Healthy Futures Initiative for Foundation for a Healthy Kentucky

Section I. Program Costs

A. Project Personnel Expenses

Position/Title -Qty -Annual Salary -% Time	CNCS Share	Grantee Share	Total Amount
Program Officer - Year One: - 1 person(s) at 60000 each x 100 % usage	30,000	30,000	60,000
Program and Administrative Coordinator - Year One: - 1 person(s) at 42500 each x 20 % usage	4,250	4,250	8,500
Program Officer - Year Two: - 1 person(s) at 63000 each x 100 % usage	31,500	31,500	63,000
Program and Administrative Coordinator - Year Two: - 1 person(s) at 44625 each x 20 % usage	4,462	4,463	8,925
CATEGORY Totals	70,212	70,213	140,425

B. Personnel Fringe Benefits

Purpose -Calculation	CNCS Share	Grantee Share	Total Amount
FICA:	0	0	0
Health Insurance:	0	0	0
Retirement:	0	0	0
LIfe Insurance:	0	0	0
Benefits for Project Staff - Year One: 30% of Salary	10,275	10,275	20,550
Benefits for Project Staff - Year Two: 30% of Salary	10,789	10,789	21,578
CATEGORY Totals	21,064	21,064	42,128

C. Travel

Purpose -Calculation	CNCS Share	Grantee Share	Total Amount
Grantee, Staff and Board Travel - Year One: Grantee travel to workshop series; Staff and Board member travel for site visits	10,000	10,000	20,000
Grantee, Staff and Board Travel - Year Two: Grantee travel to workshop series; Staff and Board member travel for site visits	15,000	15,000	30,000
CATEGORY Totals	25,000	25,000	50,000

D. Equipment

Item/Purpose -Qty -Unit Cost	CNCS Share	Grantee Share	Total Amount

CATEGORY Totals	0	0	0

E. Supplies

Item -Calculation	CNCS Share	Grantee Share	Total Amount
Computer and Desktop Supplies for Program Officer - Year One:	475	475	950
Grantee Webinars - Year One: Software and Materials	1,000	1,000	2,000
CATEGORY Totals	1,475	1,475	2,950

F. Contractual and Consultant Services

Purpose -Calculation	CNCS Share	Grantee Share	Total Amount
External Evaluation - Center for Community Health and Evaluation (CCHE) - Year One: 10% of program budget	100,000	100,000	200,000
Technical Assistance Workshop Series - Year One: Speaker Fees and Facilities Rental for 4 2-day workshops	24,000	24,000	48,000
External Evaluation - Center for Community Health and Evaluation (CCHE) - Year Two): 10% of program budget	100,000	100,000	200,000
Technical Assistance Workshop Series - Year Two: Speaker Fees and Facilities for 6 2-day workshops	36,000	36,000	72,000
CATEGORY Totals	260,000	260,000	520,000

H. Other Costs

Purpose -Calculation	CNCS Share	Grantee Share	Total Amount
Subgrants:	1,621,311	1,621,311	3,242,622
Criminal History Checks - Year One:	563	562	1,125
Criminal History Checks - Year Two:	375	375	750
CATEGORY Totals	1,622,249	1,622,248	3,244,497
SECTION Totals	2,000,000	2,000,000	4,000,000
PERCENTAGE	50%	50%	

Section II. Indirect Costs

J. Federally Approved Indirect Cost Rate

Calculation -Cost Type -Rate -Rate Claimed -Cost Basis	CNCS Share	Grantee Share	Total Amount
: Total Direct Costs: with a rate of 29 and a rate claimed of 29	23,200	23,200	46,400

CATEGORY Totals	23,200	23,200	46,400
SECTION Totals	23,200	23,200	46,400
PERCENTAGE	50%	50%	

BUDGET Totals	2,023,200	2,023,200	4,046,400
PERCENTAGE	50%	50%	

Source of Funds

Section	Match Description	Amount	Type	Source
Source of Funds	Foundation assets	2,023,200	Cash	Private
Total Source of Funds		2,023,200		